Plan Name	**Plan Phone Number**
Anthem Blue Cross HIPAA PPO Share 1500 DL97 01-01-2009	1-800-333-0912

This benefit summary is intended to help you compare coverage and benefits and is a summary only. For a more detailed description of coverage, benefits, and limitations, please contact the health care service plan or health insurer. The comparative benefit summary is updated annually, or more often if necessary to be accurate. The most current version of this comparative benefit summary is available on www.anthem.com/ca. You may contact the Department of Managed Health Care at (888) HMO-2219 for further assistance regarding the matrix.

Eligibility requirements	**Who is Eligible for Coverage (*1)** The Subscriber is the person listed as the applicant whose Individual Enrollment Application has been approved and accepted by us for coverage under this Agreement. Family Members are the following Members of the Subscriber's family who are eligible and accepted under this Agreement: • The Subscriber's lawful spouse of the opposite sex. • The Subscriber's Domestic Partner, subject to the following: The Subscriber and Domestic Partner have completed and filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code. The Domestic Partner does not include any person who is covered as a Subscriber or Spouse. • Any children of the Subscriber or the Subscriber's enrolled spouse or enrolled Domestic Partner who are under age 19. • Any unmarried children of the Subscriber or the enrolled spouse or enrolled Domestic Partner who are between the ages of 19 and their 23rd birthday, provided they are dependent upon them for at least half of their support. If your dependent does not meet the qualifications to remain as a dependent on your plan, Anthem Blue Cross will automatically enroll your dependent, if a resident of California, on the same Plan, under his/her own identification number. • Any of the Subscriber's, enrolled spouse's or enrolled Domestic Partner's children who are both incapable of self- sustaining employment due to a continuedphysically or mentally disabling injury, illness, or condition and who are chiefly dependent upon the Subscriber, the enrolled spouse or enrolled Domestic Partner for support. At least ninety (90) days prior to a child reaching the limited age for coverage, Anthem Blue Cross will send a notice to the Subscriber who must submit written proof of such dependency and incapacity within sixty (60) days of receiving the request. Before the child reaches the limiting age, Anthem Blue Cross will determine whether the child meets the criteria for continued coverage. After two years following the child reaching the limiting age, Anthem Blue Cross may request proof of continuing incapacity and dependency, but not more often than annually. Anthem Blue Cross may request a new Subscriber to provide information regarding a dependent child to ensure the child continues to meet the conditions above at the time of enrollment and not more than annually thereafter for proof that the child meets the criteria for continued coverage. The Subscriber must submit written proof of such dependency within sixty (60) days of receiving the request. • • Newborns of the Subscriber or the Subscriber's enrolled spouse or enrolled Domestic Partner for the first thirty-one (31) days of life. TO CONTINUE COVERAGE, THE NEWBORN MUST BE ENROLLED AS A FAMILY MEMBER BY NOTIFYING ANTHEM BLUE CROSS IN WRITING WITHIN SIXTY (60) DAYS OF BIRTH AND THE SUBSCRIBER WILL BE RESPONSIBLE FOR ANY ADDITIONAL SUBSCRIPTION CHARGES DUE EFFECTIVE FROM THE DATE OF BIRTH. NEWBORNS OF THE SUBSCRIBER'S DEPENDENT CHILDREN ARE NOT COVERED UNDER THIS AGREEMENT. • A child being adopted by the Subscriber will have coverage up to thirty-one (31) days from the date on which the adoptive Child's birth parent or appropriate legal authority signs a written document granting the Subscriber, the enrolled spouse or enrolled Domestic Partner the right to control health care for the adoptive Child, or absent this document, the date on which other evidence exists of this right. TO CONTINUE COVERAGE, THE ADOPTED CHILD MUST BE ENROLLED AS A FAMILY MEMBER BY NOTIFYING US IN WRITING WITHIN SIXTY (60) DAYS OF THE DATE THE SUBSCRIBER'S AUTHORITY TO CONTROL THE CHILD'S HEALTH CARE IS GRANTED AND THE SUBSCRIBER WILL BE RESPONSIBLE FOR ANY ADDITIONAL SUBSCRIPTION CHARGES DUE EFFECTIVE FROM THE DATE THE SUBSCRIBER'S AUTHORITY TO CONTROL THE CHILD'S HEALTH CARE IS GRANTED.
The premium cost of each benefit package in the service area in which the individual and eligible dependents work or reside	Premiums charged by plans vary by region and age of subscribers.

When and under what circumstances benefits cease	**When the Member Becomes Ineligible** A Member becomes ineligible for coverage under this Agreement when: 1. The Subscriber does not pay the subscription charges when due. 2. The spouse is no longer married to the Subscriber. 3. The Domestic Partnership has terminated and the Domestic Partner no longer satisfies all eligibility requirements specified for Domestic Partners. 4. The child fails to meet the eligibility rules listed above. 5. The Member fails to cancel any other coverage upon becoming enrolled under this Agreement. 6. The member becomes eligible for coverage under a group health plan or Medi-Cal. 7. A Member is absent from California for more than six (6) months. Anthem Blue Cross may terminate, cancel or decline to renew this Agreement in the event of any of the following: 1. Your failure to pay subscription charges as required herein. If you fail to pay subscription charges as they become due, Anthem Blue Cross may terminate this Agreement only upon first giving you a written Notice of Cancellation at least fifteen (15) days prior to that termination. The termination will be effective as of 12:00 midnight on the fifteenth (15th) day after the date on which the Notice of Cancellation is sent. The Notice of Cancellation shall state that this Agreement shall not be terminated if you make appropriate payment in full within fifteen (15) days after Anthem Blue Cross issues the Notice of Cancellation. The Notice of Cancellation also shall inform you that, if this Agreement is terminated for nonpayment and you wish to apply for reinstatement, you will be required to submit a new application for coverage and will be required to submit any dues that are owed, in addition to a $50 reinstatement fee, and you will be subject to medical underwriting. 2. With prior written notice if your or any Family Member's fraud or deception in the submission of claims or use of services or facilities of Anthem Blue Cross, or your knowingly permitting such fraud or deception by another. Termination shall be effective on the date specified in the notice, but not earlier than thirty-one (31) days after the date of the notice. 3. On the first of the month following our receipt of your written notice to cancel. 4. Upon becoming ineligible for this coverage. See the section, When the Member Becomes Ineligible, in the PART entitled ELIGIBILITY. Termination shall be effective on the date specified in the notice, but not earlier than thirty-one (31) days after the date of the notice. 5. If we decide to leave the individual market and if we have given the Director of the Department of Managed Health Care at least 180 days prior written notice, we may terminate this Agreement. We will give you written notice of any such termination, and any such termination shall be effective on the date and at the time specified in the notice, but it will in no event be earlier than 180 days following the date of the notice. 6. If we decide to discontinue this plan and if we have given the Director of the Department of Managed Health Care at least 90 days prior written notice, we may terminate this Agreement. We will give you written notice of any such termination, and any such termination shall be effective on the date and at the time specified in the notice, but it will in no event be earlier than 90 days following the date of the notice. We would make available continued coverage under any of the other plans we offer to individuals, without regard to your health status. 7. If you are in the Hospital or Skilled Nursing Facility on the date we cancel your coverage on written notice as described in paragraph 6, benefits will continue until whichever of the following occurs first: a. The date of discharge from the Hospital or Skilled Nursing Facility, or b. Care or treatment is no longer Medically Necessary, or c. The maximum benefits have been furnished.

The terms under which coverage may be renewed	The duration of your coverage under this Agreement depends on how your subscription charges are billed, and is equal to the length of time between billing cycles. For example, if we bill subscription charges on a bi-monthly basis, your coverage is for a two-month duration. If we bill subscription charges on a quarterly basis, your coverage is for a three-month duration. If you have chosen Anthem Blue Cross' monthly checking account deduction program, or are a member of a list bill program, or if we otherwise bill subscription charges on a monthly basis, your coverage is for a one-month duration. The duration of the Agreement is determined by how you pay your subscription charges (measured from the effective date of coverage) and is unrelated to, and is not affected by, the use of other periods of time to measure or determine your rights or benefits, such as, for example, the use of a calendar year or other Deductibles.		
Other coverage that may be available if benefits under the described benefit package cease	Member may apply and be medically underwritten for an Individual Plan.		
The circumstances under which choice in the selection of physicians and providers is permitted	Members have a free choice of licensed physicians and providers. However, benefits are specifically designed to encourage members to use plan preferred/participating providers. Preferred/participating providers include certain physicians, hospitals, alternate care services providers, and other providers. Members pay a higher copayment amount and any amount in excess of network rates for services rendered by non-preferred/non-participating providers.		
Benefit Summary (*3) & (*4)	**Co-payments (Member's Payment Responsibility)**		**Limitation**
Lifetime and annual maximums	**$6,000** Yearly maximum copayment/coinsurance limit per member (*2) Two (2) member maximum (Please consult the plan's Evidence of Coverage for more detailed information and exclusions.)		**$5,000,000** lifetime maximum benefits paid by Anthem Blue Cross
Deductibles	**$1,500** annual deductible per member (*2) Two (2) member maximum (Please consult the plan's Evidence of Coverage for more detailed information and exclusions.)		
Professional Services	Physician office visits, including, but not limited to preventive care, immunizations, screenings and diagnostic visits.	Participating Provider: 30% of Negotiated Fee Rate (NFR) Non-Participating Provider: 50% of the NFR plus all charges in excess of the NFR	
Outpatient Services	Outpatient services, including, but not limited to surgery and treatment, and diagnostic procedures.	Preferred Participating Provider: 30% of the Negotiated Fee Rate (NFR) Participating Provider: 30% of the NFR plus a $500 admission charge for surgery or infusion therapy Non-Participating Provider: All charges in excess of an Anthem Blue Cross maximum payment of $380 per day	The Member is responsible for a $500 admission charge per admission for inpatient services or when an outpatient visit is related to surgery or Infusion Therapy at a Participating Hospital. This admission charge is separate from any Deductible required by this Agreement. It does not apply toward satisfying the Member's Yearly Deductible or Maximum Copayment/Coinsurance Limit. The admission charge will not be required for Medical Emergency admissions or Ambulatory Surgical Centers.

Benefit Summary (*3) & (*4)		**Co-payments (Member's Payment Responsibility)**	**Limitation**
Hospitalization Services	Inpatient and outpatient services, including, but not limited to room board and supplies.	Preferred Participating Provider: 30% of the Negotiated Fee Rate (NFR) Participating Provider: 30% of the NFR plus a $500 admission charge Non-Participating Provider: All charges in excess of an Anthem Blue Cross maximum payment of $650 per day	The $500 admission charge will not be applied towards the member's yearly maximum copayment/coinsurance limit or deductible.
Emergency Health Coverage	Emergency room services at contracted and non-contracted facilities for medically necessary emergency services.	PROFESSIONAL SERVICES • Participating Provider: 30% of the Negotiated Fee Rate (NFR) • Non Participating Provider: 30% of Customary and Reasonable (C&R) charges or billed charges, whichever is less, plus all the charges in excess of C&R HOSPITAL SERVICES • Participating Hospital: 30% of the NFR • Non-Participating Hospitals: 30% of C&R charges or billed charges, whichever is less plus all charges in excess of C&R for the first 48 hours. After 48 hours, you pay all charges except $650 per day. If the Member has not been stabilized sufficiently to be safely transferred to a Participating facility after the first 48 hours, then the Member's payment will remain at 30% of the Customary and Reasonable Charge **plus** all charges in excess of Customary and Reasonable until his/her condition permits transfer to a Participating facility. AMBULATORY SURGICAL CENTER (ASC) • Participating Provider: 30% of the NFR • Non-Participating Provider: 30% of C&R charges plus all charges in excess of C&R AMBULANCE SERVICES • Participating Provider: 30% of the Negotiated Fee Rate • Non-Participating Provider: 30% of customary and reasonable charges plus all charges in excess of customary and reasonable	Emergency Room services for both Participating and Non-Participating Providers are subject to an additional $100 Emergency Room Copayment per visit, which is waived if the visit results in an inpatient admission immediately following the Emergency Room services.
Ambulance Services	Emergency ambulance transport.	AMBULANCE SERVICES IN A MEDICAL EMERGENCY • Participating Provider: 30% of the Negotiated Fee Rate (NFR) • Non-Participating Provider: 30% of C&R charges plus all charges in excess of C&R	

Benefit Summary (*3) & (*4)		Co-payments (Member's Payment Responsibility)	Limitation
Prescription Drug Benefits	Medically necessary drugs prescribed by a physician.	PARTICIPATING RETAIL PHARMACIES • For Drugs on the Anthem Blue Cross Formulary: o Generic - $10 Copayment o Brand – 100% of Negotiated Fee for all Brand Name Drugs until $250 Brand Name Prescription Drug Deductible is satisfied o After $250 Brand Name Prescription Drug Deductible is satisfied: $30 Copayment if a Generic equivalent is not available o $10 Copayment **plus** the difference in cost, based on the Negotiated Fee when purchased at a Participating Pharmacy, between the Brand Name and the Generic equivalent for Brand Name Drugs if a Generic equivalent is available o For Self-Injectables (except insulin) - 30% of the Negotiated Fee • For Drugs **not** on the Anthem Blue Cross Formulary: o 50% of the Negotiated Fee for Generic Drugs o 100% of the Negotiated Fee for Brand Name Drugs until the $250 Brand Name Prescription Drug Deductible is satisfied o After $250 Brand Name Drug Deductible has been satisfied: 50% of the Negotiated Fee for Brand Name Drugs if a Generic equivalent is not available o $10 Copayment plus the difference in cost, based on the Negotiated Rate when purchased at a Participating Pharmacy, between the Brand Name and the Generic equivalent for Brand Name Drugs if a Generic equivalent is available o For Self-Injectables (except insulin) – 30% of the Negotiated Fee NON-PARTICIPATING RETAIL PHARMACIES • Copayment as stated for Participating Pharmacies **plus** 50% of the Drug Limited Fee Schedule (DLFS) and all charges in excess of the DLFS MAIL ORDER • Generic-$10 Copayment • Brand: After the $250 Brand Name Prescription Drug Deductible • Brand Name Drugs if a generic equivalent is not available: $30 Copayment per each 30-day supply up to a maximum 60-day supply • Brand Name Drugs if a Generic equivalent is available: $10 copayment plus the difference between the Brand Name and the Generic for each 30-day supply, up to a maximum 60-day supply	Each Member must meet a Brand Name Prescription Drug Deductible amount of $250 each Year. This Deductible is separate from the annual Deductible for medical benefits and does not accumulate towards satisfying the medical Yearly Maximum Copayment/Coinsurance Limit. The first two (2) Members of an enrolled family to satisfy their Brand Deductible in full will satisfy this Deductible for the entire family. RETAIL: 30 day supply MAIL ORDER: 60 day supply

Benefit Summary (*3) & (*4)		**Co-payments (Member's Payment Responsibility)**	**Limitation**
Durable Medical Equipment	Home medical equipment, including, but not limited to, oxygen, parenteral and enteral nutrition, colostomy supplies, corrective prosthetics and aids, and diabetic supplies.	Participating Provider: 30% of the Negotiated Fee Rate (NFR) Non-Participating Provider: 50% of the NFR plus all charges in excess of the NFR	Footwear limited to a maximum of $400 per year for Participating and Non-Participating Providers combined. Covered Medically Necessary footwear prescribed to treat conditions of Diabetes will be charged against the maximum benefit of $400 per Year, but the amount of benefits will not be subject to the maximum benefit.
Mental Health Services	Inpatient and outpatient mental health services, including, but not limited to, mental health parity services for serious mental disorders and severe emotional disturbances for children.	INPATIENT HOSPITAL AND DAY TREATMENT PROGRAM *Limited to 30 visits per Year for Participating and Non-Participating Providers Combined. After 30 days, you pay all charges for the remainder of that Year. Benefits for inpatient/day treatment Mental Health Services are also combined with benefits for Chemical Dependency services.* • Participating Provider: All of the Negotiated Fee Rate (NFR) except $175 per day. • Inpatient Non-Participating Provider: All charges except $175 per day PROFESSIONAL SERVICES *Limited to 1 visit per day and 20 visits per Year for Participating and Non-Participating Providers combined. Benefits for Professional Mental Health Services are also combined with benefits for Chemical Dependency services.* • Professional Participating Provider: All of the NFR except $25 per visit. • Professional Non-Participating Provider: All charges except $25 per visit *Services for Severe Mental Illnesses and Serious Emotional Disturbances of a Child: Copay and benefit levels provided are the same as for any other medical condition*	Mental Health Services limitations do not apply to the treatment of Severe Mental Illnesses and Serious Emotional Disturbances of a Child. For purposes of Severe Mental Illnesses and Serious Emotional Disturbances of a Child only, a Skilled Nursing Facility will also include a residential treatment center which is an inpatient treatment facility where the Member resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a Mental Disorder or Substance Abuse. . The facility must be licensed to provide psychiatric treatment of mental disorders or rehabilitative treatment of Substance Abuse according to state and local laws.
Residential Treatment	Transitional residential recovery services.	**See Custodial care and skilled nursing facilities below.**	

Benefit Summary (*3) & (*4)		**Co-payments (Member's Payment Responsibility)**	**Limitation**
Chemical Dependence Services	Substance abuse treatment or rehabilitation.	INPATIENT HOSPITAL AND DAY TREATMENT PROGRAM *Limited to 30 visits per Year for Participating and Non-Participating Providers Combined. After 30 days, you pay all charges for the remainder of that Year. Benefits for inpatient/day treatment Chemical Dependency Services are also combined with benefits for Mental Health services.* • Participating Provider: All of the Negotiated Fee Rate (NFR) except $175 per day. • Inpatient Non-Participating Provider: All charges except $175 per day PROFESSIONAL SERVICES *Limited to 1 visit per day and 20 visits per Year for Participating and Non-Participating Providers combined. Benefits for Professional Chemical Dependency Services are also combined with benefits for Mental Health services.* • Professional Participating Provider: All of the NFR except $25 per visit. • Professional Non-Participating Provider: All charges except $25 per visit	Inpatient: 30 days per year maximum, combined with inpatient mental health services (except for services for severe mental illnesses and serious emotional disturbances of a child). Professional: One visit per day, 20 visits per year maximum, combined with mental health services.
Home Health Services	Home health and hospice care services. (*5)	Participating Provider: 30% of the Negotiated Fee Rate Non-Participating Provider: All charges except $75 per visit	60 visits per year maximum, Participating and Non-Participating Providers combined up to 4 hours each visit.
Custodial Care and skilled nursing facilities	Skilled Nursing care and skilled nursing facilities services.	Participating Provider: 30% of the Negotiated Fee Rate Non-Participating Provider: All charges except $150 per day *Maximum of 100 days per year maximum for Participating and Non Participating Providers combined.*	For purposes of Severe Mental Illnesses and Serious Emotional Disturbances of a Child only, a Skilled Nursing Facility will also include a residential treatment center which is an inpatient treatment facility where the member resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a mental disorder or substance abuse. The facility must be licensed to provide psychiatric treatment of mental disorders or rehabilitative treatment of substance abuse according to state and local laws. Custodial care is not a covered benefit under this plan.

(*1) To be eligible under this plan a Member must meet all of the following conditions:

a) has had eighteen (18) or more months of creditable coverage without a break of sixty-three (63) days or more between any of the periods of creditable coverage or since the most recent coverage was terminated, and whose most recent creditable coverage was under a group health plan (including Cal-COBRA or COBRA), a federal government plan maintained for federal employees, or a governmental plan or church plan as defined in the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1002), and
b) is not eligible for coverage under a group health plan, Medicare, or Medi-Cal, and does not have any other health coverage, and
c) was not terminated from his or her most recent creditable coverage due to nonpayment of premiums or fraud, and
d) if offered continuation coverage under COBRA or Cal-COBRA, has elected and exhausted that coverage.

(*2) The first two (2) members of an enrolled family to satisfy their individual deductibles in full will satisfy the deductible for the entire family. Once the family deductible is satisfied, no further deductible is required for the remainder of that year. However, we will not credit any deductible over and above the family deductible maximum that was applied but did not satisfy an individual member's deductible amount in full.

(*3) This is a benefit summary. Please consult the individual plan's Evidence of Coverage for more detailed information on benefits under the plan, including any related exclusions not contained in this benefit summary.

(*4) Percentage co-payments present a percentage of actual cost. When participating providers are compensated on a fee for service basis, the actual cost is the negotiated fee rate. In a PPO, percentage copayments for non-emergency services provided by non-participating providers are a percentage of usual, customary or reasonable rates or billed charges whichever is less, and enrollees are also responsible for any excess amount.

(*5) Hospice benefits are available through the plan. Please consult the plan's Evidence of Coverage.